

<b>Case Number:</b>	CM14-0166443		
<b>Date Assigned:</b>	10/13/2014	<b>Date of Injury:</b>	07/10/2007
<b>Decision Date:</b>	11/13/2014	<b>UR Denial Date:</b>	09/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is licensed in Psychology and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records provided for this IMR, this patient is a 54-year-old male who reported an industrial injury that occurred on July 10, 2007. The injury reportedly occurred when a crane carrying concrete ran over his left leg, crushing it, and requiring amputation below the knee. Medical diagnoses include: Below the Knee Amputation; Thoracic and Lumbar Spasm; Phantom Limb Pain Rule out CRPS; Insomnia; Vertigo; Syncope Unknown Origin; Status Post Stump Revision; History of Stump Abscess (Second One). Post amputation, his wound became infected and there were multiple surgeries and difficult medical procedures. This IMR will focus on his symptoms that relate to psyche as they pertain to the current request for family counseling times eight sessions. A treatment note from June 2014 states that he was trying to see a psychiatrist or a psychologist for 4 and a half years and then finally underwent a QME and was referred by the QME for therapy and treatment. He reports continued depression since the injury seven years ago. He complains of depressed mood, anhedonia, insomnia, low energy, anxiety, worry, restlessness, and irritability. He was originally prescribed Cymbalta but stopped taking it after two weeks due to increased anxiety. He considered suicide when the injury first occurred but was unable to go through with it because he felt like something was holding him back and calming him down and he is not considered it again since that time. He isolates himself from his friends is constantly short-tempered at his children and feels worthless. A treatment plan from July 23, 2014 and again in September 17, 2014; continues group therapy and counseling clinic. The treatment plan states that the request for authorization is for "an additional eight therapy sessions with [REDACTED] family therapist." He has been receiving monthly psychiatric care and is prescribed 40 mg of Prozac. The most recent treatment note from his psychiatrist from August 2014 states that the patient has noticed a slight decrease in his depressed moods and energy level is still very low but he is entertaining the thought of getting out and doing things outside of the

home, is taking his Prozac as prescribed and denies anxiety or restlessness or suicide/homicidal ideation. "Mood is sad but there is occasional laughing and smiling." Psychiatric diagnoses: Major Depressive Disorder, Single Episode, Mild Degree. In addition to his psychiatric treatment he has been receiving individual cognitive therapy and also family therapy with his wife. Hand written treatment progress notes from the psychologist were provided but difficult to read. The cognitive behavioral individual session progress note states that they are working on helping to him to accept and adjust to the traumatic injury, working on PTSD symptoms, working on issues of coping with pain, and anxiety. In the third individual therapy session dated July 2014 the note again discusses the traumatic injury that he experienced as well as his symptoms of PTSD including flashbacks and how it's affected him, his family, and his ability to engage in life in many respects. Progress notes from his third family session conducted with the patient and his wife states that they have had to deal with the impact of his injury as it affects both her and their son and they worked on communication skills. A medical note from May 7, 2014 mentions that he and started the family counseling recently. A medical treatment note from August 2011 refers to a report from his "psyche [REDACTED]" (actually [REDACTED], who two years later performed a psychological evaluation October 2013) at that time but no further details were provided. A progress note from October 2009 states that the patient continues to see [REDACTED] for psychiatric treatments. However, a psychological progress report dated April 2014 was provided identifies [REDACTED] as a clinical health psychologist and not a psychiatrist. The progress note indicates that he is working on learning to speak about his feelings and to focus on the small progress is that he's making between sessions to better understand whether or not he is making progress. The patient mentioned that at a family gathering he approached some relatives and apologized for past statements that he had made. In May 2014 another psychological progress note was noted that he is increased guitar playing and attempted to go out onto the golf course after being given a golf bag. Another note from April 2014 states that the psychologist has pushed him to speak more about his accomplishments and that he said that he has been doing more yard work 2 to 3 hours a week. A psychological evaluation from October 2013 stated that the patient has had previous psychological evaluations February 2010, December 2010, June 2011, and January 2013 all conducted by the same psychologist. He was been diagnosed with the following: Major Depressive Disorder, Chronic, Moderate; Adjustment Reaction with Depression and Anxiety, Chronic; Pain Disorder Associated with Psychological in General Medical Factors; Posttraumatic Stress Disorder; Insomnia and Hypoactive Sexual Desire Disorder. He notes that his psychological treatments have been helpful but he is still having a lot of problems controlling his emotions and irritability with his wife and son. And that his wife has given up on him. His wife feels that the psychologist is not helping his explosive anger and he recognizes that he is still having a lot of trouble controlling his frustrations. He requests medications that would calm him down and help to ease his reactivity and feels that he is not making much progress by talking about the problem. There is also a notation that psychiatric medications are needed but have been repeatedly denied. This IMR will address a request for 8 additional sessions of family therapy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

The Final Determination was based on decisions for the disputed items/services set forth below:

**8 sessions of Family Counseling:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Psychological Treatments

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions, Psychological Treatment Page(s): 101-102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness And Stress Chapter, Topic: Cognitive Behavioral Therapy, Psychotherapy Guidelines, June 2014 Update

**Decision rationale:** According to the MTUS treatment guidelines, psychological treatment is recommended for appropriately identified patients during treatment for chronic pain.

Psychological intervention for chronic pain includes: setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive functioning, and addressing comorbid mood disorders such as depression, anxiety, panic disorder, and PTSD. The identification and reinforcement of coping skills is often more useful in the treatment of chronic pain and ongoing medication or therapy which could lead to psychological or physical dependence. An initial treatment trial is recommend consisting of 3-4 sessions (up to 6 sessions according to the Official Disability Guidelines) to determine if the patient responds with evidence of measureable/objective functional improvements. Guidance for addition sessions is a total of up to 6-10 visits over a 5 to 6 week period of individual sessions.

The official disability guidelines allow somewhat more of an extended treatment and recommend 13-20 sessions maximum for most patients who are making progress in their treatment; in some unusually complex and severe cases of Major Depression (severe intensity) and/or PTSD up to 50 sessions if progress is being made. This patient presents with an unclear history of prior psychological treatments. In order to determine the medical necessity of additional psychological treatments these issues must be addressed: significant patient psychological symptomology, objective functional improvements based on prior sessions, and the duration and quantity of prior treatment. Treatment progress notes were provided and provided substantial detail of the sessions but did not reflect sufficient changes in objective functional improvements. The entire duration of all of his psychological treatment is unclear. He appears to have had multiple psychological evaluations throughout the years since his injury and there is some indication that he was unable to obtain psychological treatment but then there is other indications suggesting that he has had psychological treatment and it was not possible to reconcile these two points of view based on the information that was provided. Although it has been established by the medical records that were provided that the patient is experiencing continued psychological symptomology that would be addressed in family therapy sessions primarily his anger outbursts, the other two criteria are not adequately met. The efficacy of the prior family therapy treatment and prior psychological treatment on the symptom of his anger outbursts is not shown as contributing significant improvements, the patient and his wife both stated that the symptom does not appear to be improving. The patient requests medication for this symptom and anger outbursts are often treatable with psychiatric medication. The lack of demonstrated objective functional improvements makes the request for additional sessions of family therapy unsupported as medically necessary.